ARIZONA DEPARTMENT OF HEALTH SERVICES

OFFICE OF HEALTH CARE LICENSURE
MEDICAL FACILITIES SECTION

ADDITIONAL INFORMATION NEEDED FOR LICENSING OF A HOME HEALTH AGENCY

PARENT FACILITY NAME LIC.#
ADDRESS

1. Hours of operation: (indicate hours clinic is open, i.e., 8-4; 12-6)

Sun	Mon	Tue	Wed	Thur	Fri	Sat

2. BRANCHES	ADDRESS:

3. SUBUNITS	ADDRESS:	LICENSE NO.

4. Attach Organizational Chart

5. Pursuant to ARS §36-151(3)(5): **THE AGENCY MUST BE PRIMARILY ENGAGED IN PROVIDING SKILL NURSING SERVICES AND OTHER THERAPEUTIC SERVICES. THE AGENCY MUST PROVIDE AT A MINIMUM PART-TIME OR INTERMITTENT NURSING CARE AND EITHER PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY, OR PART-TIME OR INTERMITTENT SERVICES OF A HOME HEALTH AIDE.**

SERVICE	PROVIDED DIRECTLY BY HOME HEALTH AGENCY	PROVIDED THROUGH ARRANGEMENT WITH OTHERS
NURSING		
PHYSICAL THERAPY		
SPEECH THERAPY		
OCCUPATIONAL THERAPY		
MEDICAL SOCIAL SERVICE		
HOME HEALTH AIDE		
OTHER (IDENTIFY)		

6. Attach resumes of Administrator, Alternate Administrator and Supervising Nurse.

7. Describe specifically the geographic area to be served. Include the approximate mileage within the radius of the geographic area. (i.e., patients located within a radius of 65 miles from parent office)

8. Age Group	
All Ages	
Selected ages (Specify)	

9. Current census of private and medicare/AHCCCS patients		
Average Daily Patient Census		
Current census of Medicare patients		
Number of unduplicated Medicare/AHCCCS/ALTCS (Medicaid) patients admitted in the previous 12 months.		

10. Staffing List	Full-Time	Part-Time	Full-Time Equivalent
Registered Nurses			
Licensed Practicing Nurses			
Home Health Aide			
Physical Therapist			
Occupational Therapist			
Speech Therapist			
Other:			

11. Submit proof of fingerprinting for all current employees providing direct patient care including the administrator and supervising nurses. Pursuant to A.R.S. §36-411. (Copy of finger printing rosters.)

I,_____, attest that all direct
Print Name
patient care employees including the administrator and supervising nurse have submitted proof of fingerprinting.

_____
Signature

12. **Submit proof of annual TB screening for all current employees providing direct patient care. Pursuant to R9-10-1103(B)(1)(2).**

I,_____, attest that all
Print Name
employees have had a current annual TB screening.

_____
Signature

REV. 03/02/2000 * REV. 06/20/01